2007 PERS Select & PERS Choice Benefit Summary

BENEFITS	PERS Select/PERS Choice	
CALENDAR YEAR DEDUCTIBLE	*(Not transferable between plans)*	
	Your Cost	
Individual	$500	
Family	$1,000	
HOSPITAL ADMISSION DEDUCTIBLE	**PPO**	**non-PPO**
Per Admission	100*	100*
	**Currently no deductible, $100 per admission proposed*	
MAXIMUM CALENDAR YEAR COPAY	**PPO**	**non-PPO**
Individual	$3,000	None
Family	$6,000	None
LIFETIME MAXIMUM BENEFIT	$2,000,000 *(per individual)*	
	PPO	**non-PPO**
HOSPITAL		
Hospital -- In-Patient and Outpatient	20%	40%
PHYSICIAN SERVICES		
Office Visits	$20 copay	40%
Hospital Outpatient	20%	40%
Other Professional Services	20%	40%
Preventive Care Services *(Services received for prevention and early detection of illness, including immunizations and period health exams)*	No charge	40%
Urgent Care Services	$20	40%
DIAGNOSTIC X-RAY/LAB	20%	40%
DURABLE MEDICAL EQUIPMENT *($3,000 per calendar year)*	20%	40%
AMBULANCE SERVICES	20%	20%
EMERGENCY SERVICES *($75** deductible per visit for covered ER charges -- waived if admitted to hospital)* ***Currently $50, proposed $75*	20%	20%

PRESCRIPTION DRUGS

Applies to PERS Choice and PERSCare	Generic	Preferred Brand	Non-Preferred Brand
Retail Pharmacy† *(Up to 30-day supply)*	$5	$15	$45 *($30 if partial waiver of non-preferred brand copay)*
† Short-term use			
Retail Pharmacy Maintenance Medications filled after 2nd Fill‡ *(Up to 30-day supply)*	$10	$25	*$75* *($45 if partial waiver of non-preferred brand copay*
‡ A maintenance medication taken longer than 60 days for long term or chronic conditions			
Mail Service Pharmacy *A $1,000 maximum copayment per person per calendar year applies (up to 90-day supply)*	$10	$25	$75 *($45 if partial waiver of non-preferred brand copay)*

BENEFITS	PERS Select/PERS Choice PPO	PERS Select/PERS Choice non-PPO
MENTAL HEALTH *(Includes mental health parity provisions)*		
Inpatient	20%	40%
	(Up to 20 days per calendar year)	
Outpatient	20%	40%
	(up to 24 visits per calendar year for other than severe mental illness or serious emotional disturbance of a child)	
SUBSTANCE ABUSE		
Inpatient	20%	40%
	(up to 20 days per calendar year - $12,000 lifetime maximum for any combination of inpatient and outpatient benefit)	
Outpatient	20%	40%
	(up to 24 visits per calendar year)	
HOME HEALTH SERVICES *(Precertification required; custodial care not covered)*	20% *(up to $6,000 per calendar year)*	40%
SKILLED NURSING FACILITY CARE		
(First 10 days)	20%	40%
(next 90 days)	30%	40%
(Pre certification required)		
SPEECH/PHYSICAL/ OCCUPATIONAL THERAPY		
Speech Therapy *($5,000 lifetime maximum)*	20%	40%
Physical	20%	40%
Occupational Therapy	20%	20%
($3,500 combined maximum per calendar year for physical and occupational therapy)		
HOSPICE *($10,000 lifetime maximum)*	20%	20%
CHIROPRACTIC/ACUPUNCTURE	20%	40%
(Combined benefit for Chiropractic/Acupuncture)	*(15 visits per calendar year)*	
BLOOD AND BLOOD PRODUCTS	20%	20%
HEARING AID SERVICES *($1,000 maximum in 36-month period for hearing aids)*	20%	40%